



By Electronic Mail

October 31, 2025

Mr. David Seltz  
Executive Director  
Health Policy Commission  
50 Milk Street  
Boston, MA 02109

Re: WellSense Health Plan – Health Care Cost Trends Pre-Filed Testimony

Dear Mr. Seltz:

This is in response to your request for written testimony in connection with the upcoming health care cost trends hearing to be held by the Health Policy Commission.

On behalf of WellSense Health Plan, please find our written testimony responding to the questions set forth in the 2025 Pre-filed Testimony for payers. I am legally authorized and empowered to represent WellSense Health Plan, Inc. for purposes of the written testimony herein, and sign this testimony under the pains and penalties of perjury.

If you have any questions, please do not hesitate to contact me.

Sincerely,

Signed by:

  
2CFB86B8CCC24DA...  
Diana Cruz

Acting President, WellSense Health Plan

Enclosures



# 2025 Pre-Filed Testimony **PAYERS**



As part of the  
*Annual Health Care  
Cost Trends Hearing*

## INSTRUCTIONS FOR WRITTEN TESTIMONY

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If you are receiving this, you are hereby required under M.G.L. c. 6D, § 8 to submit written pre-filed testimony for the [2024 Annual Health Care Cost Trends Hearing](#).

On or before the close of business on **Friday, October 31, 2025**, please electronically submit testimony as a Word document to: [HPC-Testimony@mass.gov](mailto:HPC-Testimony@mass.gov). Please complete relevant responses to the questions posed in the provided template. If necessary, you may include additional supporting testimony or documentation in an appendix. Please submit any data tables included in your response in Microsoft Excel or Access format.

We encourage you to refer to and build upon your organization's pre-filed testimony responses from 2013 to 2024, if applicable. If a question is not applicable to your organization, please indicate that in your response.

Your submission must contain a statement from a signatory that is legally authorized and empowered to represent the named organization for the purposes of this testimony. The statement must note that the testimony is signed under the pains and penalties of perjury. An electronic signature will be sufficient for this submission. All submissions are public record and will be posted to the [HPC's website](#).

You may receive questions from both the HPC and the Office of the Attorney General (AGO). If you have any difficulty with the templates or have any other questions regarding the pre-filed testimony process or the questions, please contact relevant staff at the information below.

### HPC CONTACT INFORMATION

For any inquiries regarding HPC questions, please contact:  
General Counsel Lois Johnson at  
[HPC-Testimony@mass.gov](mailto:HPC-Testimony@mass.gov) or  
[lois.johnson@mass.gov](mailto:lois.johnson@mass.gov).

### AGO CONTACT INFORMATION

For any inquiries regarding AGO questions, please contact:  
Assistant Attorney General Sandra Wolitzky at [sandra.wolitzky@mass.gov](mailto:sandra.wolitzky@mass.gov)  
or (617) 963-2021.

## THE 2025 HEALTH CARE COST TRENDS HEARING: PRE-FILED TESTIMONY

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The Massachusetts Health Policy Commission (HPC), along with the Office of the Attorney General (AGO), holds the Health Care Cost Trends Hearing each year to examine the drivers of health care costs and consider the challenges and opportunities for improving the Massachusetts health care system.

The 2025 Health Care Cost Trends Hearing offers a critical opportunity to discuss the pressing issues challenging stability and sustainability of the Commonwealth's health care system. These include mounting affordability issues, workforce constraints, financial volatility, increasing prescription drug costs, and threats to health care access and coverage – and the ongoing efforts to address them.

Recent federal action has created uncertainties about the health care landscape in Massachusetts. It will require a renewed commitment among stakeholders and policymakers to work together towards a health care system that is more affordable, accessible, and equitable for all residents. The 2025 Health Care Cost Trends Hearing will convene industry leaders, clinicians, and community members to reflect on recent policy actions and invite further collaborative action in Massachusetts, advancing the Commonwealth's health care goals and values.

Amid the federal activity, Massachusetts is still contending with existing affordability hardships facing the Commonwealth's residents. Massachusetts now has the highest family health insurance premiums in the country. In 2024, the average annual cost of health care for a family exceeded \$31,000 (including out-of-pocket spending). As health care spending grows as a portion of household income, more and more families incur medical debt and avoid using needed care. These rates become particularly dire when health care premiums and out-of-pocket spending reach 25% of total income – a reality that 41% of Hispanic families and 26% of Black families in Massachusetts faced in 2023 compared to 9% of white families. Furthermore, the average annual cost sharing per person grew from \$849 in 2019 to \$1,049 in 2023 (a 29% increase), and residents paying \$5,000 or more annually in cost sharing doubled from 2019 (1.5%) to 2023 (3.1%).

This is the first cost trends hearing since the enactment of two significant health care laws earlier this year (Chapters 342 and 343 of the Acts of 2024), which strengthen the health care market, address rising prescription drug costs, and enhance the public transparency and accountability of the Commonwealth's health care system – including requiring additional health care market participants to provide public testimony. As the HPC, the AGO, and other state agency partners continue implementation of these new laws, the 2025 Health Care Cost Trends Hearing will focus on working together to safeguard the Commonwealth's commitment to health care affordability, access, and equity.

The pre-filed written testimony affords the HPC and the AGO, on behalf of the public, an opportunity to engage with a broad range of Massachusetts health care market participants. In addition to pre-filed written testimony, the public hearing features in-person testimony from leading health care industry executives, stakeholders, and consumers, with questions posed by the HPC's Board of Commissioners about the state's performance under the [Health Care Cost Growth Benchmark](#) and the status of public and industry-led health care policy reform efforts.

## QUESTIONS FROM THE HEALTH POLICY COMMISSION

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1. Recent and ongoing federal policy actions are changing health care in Massachusetts. What do you anticipate will be the most significant implications of these federal actions on your organization's strategies to address health care affordability, quality, access, and equity? How is your organization working to ensure stability and mitigate any negative impacts on members and purchasers, coverage and access to care, providers, in addition to premiums and out-of-pocket costs? What specific actions should health care market participants, policymakers, and the public consider to safeguard the Massachusetts health care system against potential risks from federal policy shifts?

The One Big Beautiful Bill Act ("OBBBA") made several changes in Federal health policy, almost all of which will negatively impact BMCHS and WellSense Health Plan.

- In the Medicaid market, we anticipate that the implementation of work requirements, required by the OBBBA, on 1/1/2027 will:
  - Dramatically reduce enrollment, largely by removing from eligibility individuals whose circumstance meet the requirements of eligibility, but who failed to comply with administrative requirements of the program; and
  - Skew the risk profile of the Medicaid program by shifting the market towards concentration of enrollment by those with higher acuity.
    - Massachusetts (like other states) learned that after COVID-era protections expired and states conducted broad redetermination efforts, the overall acuity of the Medicaid population increased considerably as healthier members left the market. This phenomenon is likely to recur with work requirements as the genesis, increasing cost for insurance providers.
- Other OBBBA changes will reduce services eligible for federal financial participation (FFP). Unfortunately, many individuals require those services, which providers would often deem medically necessary.

- OBBBA and federal regulations proposed, but not yet finalized, threaten to significantly curtail access to gender-affirming care by eliminating coverage under Medicaid, the Affordable Care Act, and federal employee health plans.
  - These sweeping restrictions disproportionately impact transgender individuals—particularly those from low-income communities—by removing essential health benefits and introducing legal risks for providers. In response, Massachusetts has taken a leadership role in safeguarding this care through the passage of the Shield Act 2.0.
  - The Massachusetts legislation ensures legal protections for providers, prohibits cooperation with out-of-state investigations, and affirms the right of families to seek medically necessary care for their children.
  - As federal policies grow increasingly hostile, Massachusetts has expanded protections and acted as a safe haven by expanding provider support, reinforcing privacy protections, and ensuring that gender-affirming care remains accessible, evidence-based, and free from political interference.
- Significant restrictions placed upon eligibility of many immigrants from public programs severely impacts the work of WellSense Health Plan and BMCHS.
  - Provisions of OBBBA and the rollback of protections at sensitive locations like hospitals—have created a climate of fear that discourages non-U.S. citizens from seeking necessary medical care.
  - These changes, coupled with new restrictions on Medicaid and ACA eligibility for lawfully present immigrants, are expected to leave over 1.4 million individuals uninsured nationwide, including hundreds of thousands of Massachusetts residents.
  - Some categories of immigrants will no longer be eligible for subsidized health insurance through the Connector, while others will see their costs skyrocket with the federal government failing to fund APTCs and, as a result, the Commonwealth eliminating state wrap subsidies.

### **Financial consequences**

- With Federal limitations being placed upon the ability of states to grow their Medicaid program revenues in the future, states are being forced to make difficult choices about how to structure their program and care for their residents.
  - The Commonwealth will need to reinforce the Health Safety Net, which will experience even greater demand as Massachusetts residents are forced off Medicaid coverage.
  - Massachusetts can and should enact and enforce clear policies that protect patient privacy, prohibit immigration enforcement in healthcare settings, and ensure that all residents—regardless of status—can access care without fear, which will counteract some of the concerns around increasing acuity of our population.
  
- When the MassHealth population acuity shifted, after COVID, these changes were not sufficiently contemplated in MassHealth rates. In 2025, we estimate that the market may be underfunded by up to 15% on a full-year basis. Underfunding of this magnitude jeopardizes health plans’ financial stability and disincentivizes providers from participation in the program, which furthers access constraints.
  - WellSense strongly recommends that MassHealth work with plan actuaries to properly account for shifts in population acuity when developing rates and design stop-gap mechanisms to more quickly remedy systemic market underfunding.
  - MassHealth should also consider ways to streamline the program and reduce administrative complexity. For example, MassHealth should regularly review the reports that MCOs must regularly submit to determine whether those submissions remain useful.

2. Many Massachusetts health care providers continue to face significant workforce challenges. What policy, payment, or health care system reforms does your organization recommend to better sustain, strengthen, and diversify the health care workforce in Massachusetts?

As a provider-owned payer, WellSense Health Plan works regularly with Boston Medical Center to help sustain, strengthen and diversify the health care workforce in Massachusetts. For more details, please refer to the Boston Medical Center response to workforce questions.

3. Administrative complexity in the health care system can burden clinicians and patients and contribute to burnout, reduce timely and equitable access to care, and add unnecessary costs to the system. What are the most meaningful steps you are taking to reduce administrative complexity that provides little value to patient care? What policies or strategies should policymakers and/or other market participants consider to reduce administrative complexity that provides little value in the Massachusetts health care system? How would such changes impact your organization's administrative costs and the administrative costs of providing care borne by providers and others?

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The delicate balance that health plans - especially plans who are stewards of the public dollar - must achieve is to appropriately use tools to avoid wasteful spending on services that are not medically necessary, while ensuring minimal administrative complexity and smooth access to those services which are medically necessary. To streamline the process for appropriate approvals:

- WellSense has continued to expand our Gold Carding Program for waiving authorization requirements when appropriate for certain services, such as high-tech radiology.
- WellSense consistently reviews our list of services and procedures requiring authorization to determine whether such required authorization remains in the best interest of our members and network providers. We seek opportunities to remove or limit prior authorization requirements on specific services and procedures, without risking fraudulent or wasteful spending.
- WellSense is strategically increasing automation. By leveraging predictive analytics and clinical decision support tools, WellSense is identifying low-risk, high-volume services (e.g. imaging and SUD treatments) that can be safely removed from prior authorization requirements or automated to reduce or eliminate administrative burdens. This approach not only aligns with CMS's goal of reducing delays in care but also enhances operational efficiency and provider satisfaction.
- WellSense is also committed to leveraging existing and new technologies to minimize the administrative burden on our provider partners.
  - WellSense has successfully worked with several of our ACO partners to be able to access information through our partner's EMR's.
  - Enhanced access has greatly improved both parties' ability to confidentially and safely share data in an efficient and timely manner.

- WellSense is now able to offer providers the option to submit prior authorizations directly through our provider portal, which reduces delays and eliminates problems that regularly occurred when using fax and mail.
- We believe that these enhancements will create economies of scale for WellSense and our network providers resulting in improved administrative costs.
- Payers, providers, and policymakers need to continue to collaborate on both current and future data reporting requirements to ensure we are capturing the right level of information and not going beyond what is beneficial for patient care.
- For pharmacy:
  - WellSense is focusing on evidence-based prior authorizations that support providers and help patients quickly get the care they need.
  - WellSense is implementing a patient-safety alert program that notifies doctors about thousands of potential clinical issues based on analysis of integrated medical and pharmacy data, then summarizing these issues by level of severity for review by prescribers.
  - WellSense is developing new prior authorization technology that uses artificial intelligence to drive quick decisions for medical services by connecting electronic medical records directly to the prior authorization portal, automatically populates requests, and reduces administrative burden.
- WellSense is actively aligning with the CMS-0057 Interoperability and Prior Authorization Final Rule by modernizing its data exchange infrastructure and streamlining prior authorization workflows.
  - In accordance with the rule's mandates, WellSense is implementing HL7 FHIR-based Application Programming Interfaces (APIs), which can eventually allow for electronic prior authorization (ePA), enabling faster, more transparent communication between providers and payers.
  - These APIs can allow providers to submit ePA requests directly from their electronic health record (EHR) systems and receive timely responses.
    - WellSense will provide a response to urgent ePA requests within 72 hours and within 7 calendar days for standard requests.
  - Additionally, WellSense will meet the January 2026 and 2027 compliance deadlines for expanded patient access, provider access,

and payer-to-payer data exchange, ensuring seamless interoperability and continuity of care.

- Lastly, WellSense will begin public reporting of prior authorization metrics, such as approval rates and turnaround times, to ensure transparency and accountability.

Through these initiatives, WellSense is positioning itself as a forward-thinking health plan committed to regulatory compliance, technological innovation, and improved health outcomes.

4. High-quality, accessible primary care is foundational to an effective and efficient health care system. What specific actions or investments is your organization pursuing to enhance access to affordable, high-quality, person-centered primary care (including integrated behavioral health services) for your members? How are you tracking the impact of these activities or investments? What policy, payment, or health care system reforms does your organization recommend to enhance equitable access to high-quality primary care services?

As part of WellSense’s MassHealth ACO contract, WellSense has implemented a primary care sub-capitation program aimed at improving primary care access and investment.

- The sub-capitation program decouples primary care providers from the fee-for-service schedule, instead compensating providers through a regular, consistent payment stream.
  - Providers participating in the primary care sub-capitation program are therefore incentivized to allocate time based on patient need, rather than alternative financial incentives inherent in fee-for-service rates.
- The sub-capitation program is also used to incentivize desired services by offering additional payments for inclusion and provision of those desired services proven to result in better outcomes.
  - For example, WellSense offers additional monthly tier payments if providers offer various integrated care services, including integrated behavioral health.
  - WellSense has found that the tier payments have been a strong incentive for practices to invest in care integration.
  - WellSense tracks the impact of this program by monitoring practice tier achievement and the delivery of integrated care services in the primary care setting (as reflected in claims data).

- Our Care Management program plays a central role in improving access to high-quality, person-centered primary care by providing coordination, navigation and integrated support across medical, behavioral and social domains. We focus on proactive engagement and population health strategies that connect members to appropriate primary and behavioral health services early, reduce gaps in care and promote whole-person well-being. WellSense partners with community-based organizations to address social drivers of health (e.g., housing, food insecurity, transportation etc.) that affect a member’s ability to engage in care.

WellSense monitors clinical and utilization outcomes to evaluate the effectiveness of care management efforts. We evaluate our effectiveness based upon:

- improved HEDIS and STARS measures (e.g. follow-up after hospitalization, diabetes management, depression screening);
- member satisfaction and care coordination experience; and
- reduction in readmission and ED utilization rates.

5. In recent years, prescription drugs have been a key driver of spending growth in the Commonwealth, consistently growing at a faster rate than the state’s health care cost growth benchmark, and contributing to challenges related to health care affordability, medication access, and health disparities among Massachusetts residents. Please describe the current and anticipated pharmaceutical trends (and detail the potential impact on health care spending) in the next three to five years, including but not limited to information about anticipated trends in utilization, new medications and therapies, and price increases for brand name and generic drugs. What specific actions is your organization taking to address these trends and to balance patient access to needed medications and therapies with the imperative to offer affordable coverage for employers and members?

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WellSense has, through our partner, which also administers our prescription benefits, tracked pharmacy trend for many years. This analysis shows that in 2024, U.S. drug spending increased 8.9% for commercial plans; traditional drug spend rose 12.8% primarily due to utilization of GLP-1s, and specialty spend was up 4.9%. Surprisingly, specialty drug spend represented the lowest year-over-year increase. Medicare per-person spend increased 3.9% in 2024, driven largely by oncology spending. For Medicaid, trend rose 10.2% in 2024, largely driven by spending on anti-inflammatory medications.

- With the assistance of our partner, WellSense is forecasting overall drug trend increase of 8.2% in 2025; 7.6% in 2026; and 6.9% in 2027. These increases are expected to be largely driven by several factors.
  - We expect continued increase in utilization of weight loss medications. However, the full long-term impact of weight loss medications will be

determined by how long patients remain on weight loss medications, or whether a meaningful percentage will stop taking the medication due to side effects, or other reasons, as we have regularly seen to date.

- Continued increase in use of GLP-1s for diabetes. However, use of GLP-1s for diabetes is expected to decline after initial switches in therapy.
  - Significant increase in migraine trend due to gross cost increases and utilization increases among calcitonin gene-related peptide (“CGRP”) antagonists.
  - New gastrointestinal (“GI”) disorder treatments launching soon based on study results and FDA approval. In addition, we anticipate greater GLP-1 use for GI disorder.
- Other factors that may affect drug spend include regulation and market events resulting in more frequent price changes; potential requirements for “most favored nation” pricing at the federal level; additional direct-to-consumer engagement; and tariffs.
  - The long-term implications on cost of Inflation Reduction Act (IRA) products (drugs under CMS price negotiation) are still unknown, but will drive strategies from pharmaceutical manufacturers. The changing retail reimbursement landscape will also continue to drive changes, which is why WellSense is exploring opportunities to engage local community pharmacies to perform more clinical activities for additional remuneration. Because pharmacy is the most-used benefit, this provides additional opportunities for patient counseling and intervention (medication therapy management, point-of-sale testing, pharmacist prescribing where allowed by state law, etc.) as well as more typical pharmacist interactions like vaccinations.

Brands are expected to continue to increase above the CPI, while generics – which have been largely deflationary for many years – will likely see growth in cost due to increased utilization and patent expirations.

- WellSense works with our vendor to partner on a wide variety of initiatives to reduce the impact of cost increases and slow drug trend, including:
  - Frequent contract renegotiation with pricing improvements across all lines of business;
  - Transparent/pass-through pricing with our PBM across all lines of business;
  - Comprehensive utilization management strategies, which reduced net expenditures by approximately 13% in 2024;
  - Instituting a preferred biosimilar strategy along with generics to ensure they deliver their intended value and savings;

- Regular optimization of formularies and rebate contracting to ensure competitive net cost strategies across applicable lines of business; and
- Leveraging detailing, specialty pharmacy and provider partnerships to optimize treatment access and outcomes.

6. Massachusetts now has the highest family health insurance premiums in the United States. In 2024, the average annual cost of health care for a family exceeded \$31,000 (including out-of-pocket spending). This reflects the growth in underlying health care costs. As health care spending grows as a portion of household income, more and more families incur medical debt and avoid using needed care. Collaborative, urgent action across market participants is needed to reverse these trends. How can your organization contribute to this effort?

WellSense Health Plan is a market leader for affordability in Massachusetts. In addition to the hundreds of thousands of lives that we cover through the MassHealth program, at no cost to the members, for 2026 WellSense will be the lowest-cost option for more than 70% of the consumers in the rating areas where our merged market plans are filed and sold.

In the commercial market, WellSense Health Plan primarily serves individuals and families on low or limited incomes. Approximately 91% of our commercial membership is enrolled in the Massachusetts Health Connector's ConnectorCare plans, which are subsidized through the federal Affordable Care Act (ACA) and augmented through additional subsidy and affordability schedules authorized under a federal waiver for Massachusetts.

We file and sell the Health Connector's standard plan designs. Through ConnectorCare, those standard designs carry actuarial values that exceed the federal government's "platinum" standards for member cost sharing. This means members pay low or no cost sharing for many services, depending on their household income.

We work with providers to maintain low medical unit costs. Our provider partners appreciate that the consumers WellSense serve are primarily enrolled in Medicaid or highly subsidized ACA plans. They understand that uncompensated care is often the alternative for consumers in the coverage programs we offer or administer.

WellSense Health Plan is committed to providing a comprehensive provider network that meets or exceeds regulatory standards for adequacy. Our focus on individual coverage gives us the flexibility to maintain the kind of focused networks that have gained far less adoption in the group (employer plan sponsor) market.

We are acutely aware that we have a highly price-sensitive consumer. We know that small price differences can shift consumers in the individual market from one ACA issuer to another. We have been highly successful growing in the individual market in recent years and know that our market share can decline where we cannot maintain a low-cost position.

Cost is therefore central to our value to consumers and our strategy. We must sometimes make hard choices regarding our network to uphold our commitment to affordability, however.

In a time of provider system expansion and consolidation, there are recent examples of new owners demanding much higher rates for their acquisitions. In Central Massachusetts, this has led us to discontinue two community hospitals from our network in the last 14 months.

WellSense also finds that state reimbursement levels for care bring follow-on consequences to the rates providers seek from payers. Underfunding of uncompensated care and inadequate rates from MassHealth have a “squeeze the balloon” effect that influences commercial rate conversations.

In addition, the laudable generosity of our state’s ConnectorCare designs creates an unintended-but-real disadvantage in federal risk adjustment for WellSense. Federal risk adjustment factors stop at the actuarial value (AV) of an ACA platinum plan, which means that the induced demand of our Commonwealth’s higher-AV ConnectorCare plan designs is not adequately compensated.

Being low premium is a natural disadvantage in risk adjustment, but we face a profound dynamic in Massachusetts, where almost all of the hundreds of millions of dollars paid into risk adjustment comes from the two carriers with the largest share of the subsidized market serving limited-income individuals and families. Meanwhile, the largest receivers of those dollars are carriers with high-premium commercial group plans. Almost 20% of WellSense’s premium dollars are paid out in risk adjustment to carriers with much lower membership in Health Connector plans.

Through these observations, we seek partnership in influencing health costs. We seek it from current and potential providers for our network, and from the Commonwealth.

## TRENDS IN MEDICAL EXPENDITURES

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1. Please complete a summary table showing actual observed allowed medical expenditure trends in Massachusetts for calendar years 2021 to 2024 according to the format and parameters provided as **HPC Payer Exhibit** (attached) with all applicable fields completed. Please explain the portion of actual observed allowed claims trends that are due to (a) changing demographics of your population; (b) benefit buy down; and/or (c) change in health status/risk scores of your population for each year. Please note where any such trends would be reflected (e.g., unit cost, utilization, provider mix, service mix trend). To the extent that you have observed worsening health status or increased risk scores for your population, please describe the factors you understand to be driving those trends.

Click or tap here to enter text.

Please see the HPC Payer Exhibit 1, summarizing allowed trends from 2021 to 2024 by Utilization, Unit Cost, Provider Mix, and Service Mix for WellSense’s Massachusetts product lines.

The following supplemental chart shows our Health Status Adjusted (HSA) trends for Massachusetts in total:

Time Period	Unadjusted TME Trend	Risk Score Trend	HSA TME Trend
CY 2021	-0.5%	-4.0%	3.4%
CY 2022	1.9%	1.5%	0.4%
CY 2023	-4.5%	-14.4%	12.1%
CY 2024	11.4%	6.9%	3.9%

- Trend from 2023 to 2024 is 11.4% on an unadjusted basis, and 3.9% on a Health Status Adjusted basis. WellSense’s membership increased by 42% from 2023 to 2024 due to the following factors:
  - A new 1115 waiver period that resulted in four additional ACOs selecting WellSense as their payer-partner as of April 1, 2023. These new ACOs doubled WellSense’s MassHealth enrollment.

- WellSense’s ACA population expanded significantly due to WellSense’s lowest cost position in 2024 combined with Medicaid redeterminations reducing Medicaid enrollment, while increasing ACA enrollment.
- The federal termination of the Public Health Emergency and corresponding resumption of eligibility redeterminations in MassHealth has reduced the number of members that qualify for MassHealth from 2023 to 2024. However, the population that has remained in MassHealth post-redeterminations has a much higher acuity than the Medicaid population in 2023.
  - The overall risk score trend for MassHealth from 2023 to 2024 was 8.2%.
  - Medical expenditures are dramatically increasing on an unadjusted basis (11.4%) due to the higher acuity Medicaid population but only increasing moderately on a Health Status basis (3.9%).
- Trend from 2022 to 2023 is -4.5% on an adjusted basis, but 12.1% on a Health Status Adjusted basis.
  - This trend is due in large part to the member mix changes mentioned previously from the four additional ACOs which began operating on April, 1, 2023.
  - Membership increased by 110.7% from March to April 2023. The difference in pediatric and adult weighting after inclusion of the four additional ACOs significantly impacted reported trend.
- Trend from 2021 to 2022 is 1.9% on an unadjusted basis and .4% on a Health Status Adjusted basis. Membership increased 2.6% from 2021 to 2022, mostly due to the lack of eligibility redeterminations for MassHealth during the Public Health Emergency.

2. Reflecting on current medical expenditure trends your organization has been observing in 2025 to date, which trend or contributing factor is most concerning or challenging?

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- 2025 medical expenditures are emerging higher than 2024 by 6.1%. Redeterminations were still occurring in early 2024 but commenced by the end of the calendar year. Therefore, the MassHealth population in 2025 has a higher acuity than the 2024 Medicaid population.

- GLP-1 utilization has greatly increased across MassHealth and ACA for both anti-diabetic and weight loss indications. MassHealth approved GLP-1 drugs for weight-loss and the DOI and Connector expected ACA plans to similarly cover weight-loss GLP-1 drugs beginning on 1/1/2024.
  - Although utilization developed slowly at the beginning of 2024 due to supply shortages, utilization greatly increased throughout the year and continues to increase in 2025.
    - Across the MassHealth Adult population, spending on GLP-1 for weight loss increased from \$0.45 PMPM in January 2024 to \$25.37 at the end of 2024.
    - Total GLP-1 spend (including anti-diabetic) for the MassHealth Adult population in 2024 was \$39.55 PMPM.
    - Through August of 2025, MassHealth GLP-1 spend was \$53.26 PMPM, with spend continuing to increase month over month to around \$57.95 PMPM.
  - Across the ACA population, weight-loss GLP-1 spend increased from \$10.77 PMPM in 2024 to \$21.65 PMPM in 2025 (through August)
    - Total GLP-1 spend for ACA members was \$24.55 PMPM in 2024.
    - 2025 costs through August were \$33.88 PMPM, with spend continuing to increase month over month to a current total of around \$38.82 PMPM.
  - For CY26, WellSense ACA plans will no longer be covering GLP-1s for weight-loss.
    - We anticipate some of this utilization will move to an alternative qualifying indication (*i.e.* diabetes, sleep apnea, hypertension, etc.).
- WellSense has also witnessed a dramatic increase in Behavioral Health (BH) spend in the emerging 2025 data.
  - MassHealth BH spend is increasing 11% from 2024 to 2025 (through August).
  - Mass ACA BH spend is increasing 19% from 2024 to 2025 (through August).

## QUESTIONS FROM THE OFFICE OF THE ATTORNEY GENERAL

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1. Chapter 224 of the Acts of 2012 requires payers to provide members with requested estimated or maximum allowed amount or charge price for proposed admissions, procedures, and services through a readily available “price transparency tool.” In the table below, please provide available data regarding the number of individuals who sought this information.

**Health Care Service Price Inquiries  
Calendar Years (CY) 2023-2025**

Year	Aggregate Number of Written Inquiries	Aggregate Number of Inquiries via Telephone or In-Person
CY2023	Q1	3
	Q2	4
	Q3	3
	Q4	5
CY2024	Q1	2
	Q2	3
	Q3	4
	Q4	2
CY2025	Q1	2
	Q2	2
<b>TOTAL:</b>	<b>30</b>	<b>40</b>

# HPC Payer Exhibit 1

**\*\*All cells shaded in BLUE should be completed by carrier\*\***

Actual Observed **Total Allowed Medical Expenditure** Trend by Year  
 Fully-insured and self-insured product lines

	Unit Cost	Utilization	Provider Mix	Service Mix	Total
CY 2021	-2.6%	3.7%	1.0%	-2.5%	-0.5%
CY 2022	8.6%	-5.0%	0.4%	-1.5%	1.9%
CY 2023	12.1%	-12.8%	0.5%	-2.7%	-4.5%
CY 2024	5.5%	5.7%	0.0%	-0.1%	11.4%

**Notes:**

1. ACTUAL OBSERVED TOTAL ALLOWED MEDICAL EXPENDITURE TREND should reflect the best estimate of historical actual allowed trend for each year divided into components of unit cost, utilization, , service mix, and provider mix. These trends should not be adjusted for any changes in product, provider or demographic mix. In other words, these allowed trends should be actual observed trend. **These trends should reflect total medical expenditures which will**
2. PROVIDER MIX is defined as the impact on trend due to the changes in the mix of providers used. This item should not be included in utilization or cost trends.
3. SERVICE MIX is defined as the impact on trend due to the change in the types of services. This item should not be included in utilization or cost trends.
4. Trend in non-fee for service claims (actual or estimated) paid by the carrier to providers (including, but not limited to, items such as capitation, incentive pools, withholds, bonuses, management fees, infrastructure payments) should be reflected in Unit Cost trend as well as Total trend.